ADVICE AND RECOMMENDATIONS OF THE

ADVISORY COMMITTEE ON CAPITAL INVESTMENT IN LONG TERM CARE

July 2000

Executive Summary

"It is important that government, providers and the public do not work under the assumption that all we need to do is the same thing, only more and faster."

Capital investment in long term care is an important issue for Nova Scotians. It is a well known fact that in various parts of the province patients, who would be most appropriately cared for in alternative settings, remain in acute care facilities due to insufficient community placements. In addition, the average age of a nursing home in this province is twenty-five (25) years and most homes were designed and built in an era when residents were ambulatory and required lighter care needs than is being experienced today. Our population is aging. By the year 2016, it is projected that 18.5% of all Nova Scotians will be aged 65 and older. The status quo of continuing to do the same things in the same way is not the answer for the future.

The Advisory Committee on Capital Investment in Long Term Care adopted five basic principles and in doing so, recommends that these principles be used by government in both planning and funding capital investment in long term care. Namely,

- Ensure the fair and equitable treatment of all residents and providers.
- Maximize the use of the system's current assets.
- Level the playing field for all providers.
- Base decisions on evidence through transparent and understandable processes.
- Ensure the accountability of service providers and government.

The Advisory Committee acknowledges that communities and districts throughout the province have different assets, needs, and cultures. Our healthcare system will continue to evolve and flexibility to match solutions with local needs is required. The Committee offers four recommendations which are detailed on the following pages. Taken together, they offer a process through which our preferred future will be developed, communities and districts will develop services appropriate to their own circumstances, a long range capital and capital funding plan will be created, and processes put in place which are fair, transparent and equitable.

"We encourage government to act quickly on our recommendations - in collaboration with all health care providers and other government departments - to address the capital investment issues within the long term care sector."

Advisory Committee on Capital Investment in Long Term Care

Membership

Brian MacLeod (Chair)	MacLeod Group Inc.	Antigonish
Lloyd Brown	Northwoodcare Inc.	Halifax
Keith Menzies	Ocean View Manor	Eastern Passage
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Advice and Recommendations of the Advisory Committee on Capital Investment in Long Term Care

A. INTRODUCTION

The Advisory Committee on Capital Investment in Long Term Care was established by the Minister of Health to "provide the long term care sector perspective on strategic issues and criteria that should be considered by Government when making capital investments in long term care facilities over the next 12 to 18 months."

Simultaneously, a plan to implement single entry access to continuing care services in Nova Scotia was announced. The impact of single entry access on the demand for long term care beds in other provinces was studied by the Bed Planning Guidelines Subgroup of the Nova Scotia Provincial Long Term Care Working Group (1996). The report of this subgroup was an integral part of this Advisory Committee's research and several of the Working Group's findings and recommendations have been incorporated into this report.

The advisory committee supports government's stated commitment to develop single entry access and to integrate health services delivery at the district level, subsequently, the committee has framed its recommendations to support the evolution of a true continuum of care services reflective of the community/district.

Capital investment in long term care is a complex issue due to the systems restructuring referenced above. Over the past several months, the advisory committee has identified four key recommendations which are set forward in this report.

B. GUIDING PRINCIPLES

The following beliefs and values were adopted by the advisory committee, and are the underpinning of our recommendations:

- ***Ensure fairness to residents and providers in the transitional phase.***

  Should a transitional process be required to bridge from current to future practices, residents and providers are to be treated fairly and equitably throughout the province.

- ***Maximize the use of the system's current assets.***

  The sustainability of our health system in the longer term will be largely influenced by our ability to be both efficient and effective. It will be necessary to maximize the use of our current infrastructure within and among health sectors.

- ***Level the playing field for all providers. The same rules, standards and processes will apply to all providers regardless of ownership or proprietary nature.***

  Currently in Nova Scotia long term care facilities may be privately owned on a not-for-profit basis, privately owned on a for-profit basis, or publicly owned on a not-for-profit basis. The advisory committee notes that several other provinces have a similar ownership mix. The current balance between profit and non-profit ownership in Nova Scotia is important to retain. Equally important is the removal of any real or perceived benefit and/or bias which may accrue to a provider due to its proprietary nature.

- ***Base decisions on evidence through transparent and understandable processes.***

  Government is accountable for the prudent use of taxpayers' money, and it is imperative that decisions to repair, renovate or replace long term care facilities or to construct new beds are evidence-based, and are made in an open and accountable manner.

- ***Ensure the accountability of service providers and government.***

  Existing standards relating to capital infrastructure and investment require review to ensure adequate protection for the taxpayer and the consumer.

C. RECOMMENDATIONS

1.0 The Vision for Long Term Care in Nova Scotia

It is recommended that government establish a process through which consumers, providers, and government will develop a shared vision of long term care in Nova Scotia for the 21st century.

The advisory committee is very much aware that capital investment in long term care should be driven by consumer needs while considering optimal use of resources. At present people have few choices. They can stay at home if they can get the help they need, or they can move into long term care centers. If in the future, when home care and other options such as supportive housing are expanded, and only those people with complex and chronic health care needs reside in continuing care centers, the physical space required to support these services will be much different than was required 25 years ago.

It is envisaged that during this visioning exercise:

- The role of (and interdependence) among components of care along the care continuum, e.g. home care, in-home support, assistive/supportive housing, nursing homes, etc. will be addressed.
- Consumer participation in the visioning process will be imperative. This will present the opportunity to educate and empower the public on the continuum of care and services.
- A vehicle to build consensus from a diverse group of long term care providers will be required.

1.1 Implementation:

The Report of the Bed Planning Guidelines Subcommittee (1996) indicates that by the year 2016, 18.5 % of Nova Scotians will be aged 65 and older. 41.5% of this population is projected to be 75 years of age or older.

It is important that government, providers and the public do not work under the assumption that all we need to do is the same thing, only more and faster. A participatory process which involves communities and health service providers presents the opportunity to develop new ideas and approaches that will work for Nova Scotia in the 21st century. The advisory committee views this as an essential starting point for developing a long term care capital plan.

It is recommended that:

(a) A steering committee be established to guide the process and to co-ordinate community, district & provincial activities.
(b) Community health board and district health board structures be utilized to facilitate local community and provider input.
(c) A provincial vision statement on "Aging in Nova Scotia" be one of the outputs of this process (see Report of the Policy Advisory Committee on Aging in Alberta - 1999).
(d) This vision statement be the foundation of future local, district and provincial continuing care planning.
(e) All providers of services be brought together at the district level to develop a long-term continuing care plan for the district using the vision statement as a foundation.

2.0 Community/District Services

It is recommended that an appropriate range of services be developed in communities/districts to enable Nova Scotians to access a range of choices along the continuum responsive to their needs.

The advisory committee recognizes that the healthcare system will continue to evolve. With an aging population, the demand for continuing care services will expand and communities/districts needs will vary from one jurisdiction to another. Flexibility will be required to match solutions with local needs.

2.1 In the short-term (3-24 months):

(a) Support the development of the Single Entry Access System which has proven successful in other jurisdictions to identify needs and to concurrently develop a comprehensive range of community-based services which are targeted to individuals at risk within communities/districts.

In the early stages of single entry it can be anticipated that, if a comprehensive range of community-based services are developed, there will be a decrease in the demand for long term care beds. An objective analysis of the demand for long term care beds, over the longer term, is required to discover real trends and to determine whether a rationalization of beds is required. It is imperative, therefore, that a strategy be put in place to address the operational impact of fewer beds on long term care facilities in the short term. The stability of the sector must be protected until these real trends can be assessed. The committee recommends that the operational impact of fewer beds be compensated for in the organization's budget.

(b) Develop a transition plan for each district starting in areas of most pressing need for continuing care services:

(i) Determine profile of type and level of alternatives required in given communities/districts.

(ii) Determine capacity to offer alternatives in communities/districts by maximizing existing assets within the area.

(iii) Develop and implement required programs and services.

(iv) Construct new long term care beds only after full consideration is given to:

- development of alternatives to institutionalization to bridge gaps in care and service; and
- resources currently in the area and the capacity of these assets to be reconfigured to meet long term care bed needs.

(v) Optimize opportunities to decrease infrastructure costs by bundling services within communities/districts and by creating multi-service organizations.

2.2 In the Longer Term (2-5 years):

(a) Monitor information collected through Single Entry Access System for ongoing identification of gaps in care/service and of individuals/groups most at risk.

(b) Continue development of appropriate community-based health programs which will enable Nova Scotians to receive appropriate care at the appropriate place and time and at the appropriate cost.

(c) Construct new long term care beds if evidence of need exists and if current communities/districts resources are maximized.

(d) Follow capital plan, guidelines and procurement standards (identified in recommendations 3 and 4 below).

2.3 Standards for ALC Beds/Units

The advisory committee was advised that the transition plan in a number of districts would involve the creation of "alternate level of care" (ALC) beds/units within designated hospitals. This move is precipitated by the significant number of patients currently in acute care beds who would be most appropriately cared for in nursing homes or chronic care units, if such were available. The advisory committee was asked to comment on the appropriate standards for these ALC beds.

The accountability measures which exist for continuing care providers should also apply to providers of ALC beds. The Advisory Committee supports the development of a

tendering process for the creation of ALC beds/units to ensure that the provider(s) of same are capable of meeting standards in the most cost-effective manner.

The following are important examples of such standards but are not intended to be all inclusive:

- ALC units should be an interim strategy until the effect of single entry access and the corresponding development of additional community-based programs are achieved. They should not be seen as a long-term solution.
- The principles which underpin this report shall apply to ALC bed providers.
- ALC beds/units shall meet licensure standards and be subject to the licensure process.
- All residents of ALC beds shall undergo classification and assessment.
- External regulations such as Fire Marshall Regulations and Occupational Health & Safety Standards shall be met.
- Providers shall embrace a holistic philosophy of care which acknowledges the resident's right of self-determination and which maximizes the resident's level of independence.
- Programming and support services should be designed to address resident quality of life as well as quality of care.
- Common areas and dining areas should be provided to encourage resident socialization.
- Access to the outdoors should be provided.
- Resident privacy should be upheld.
- Residents and families should have a voice in issues which affect their quality of life and their surroundings (eg. resident & family councils or equivalents).

2.4 Guidelines for the Assessment of LTC Bed Needs

In 1996 bed planning guidelines were developed to assist communities, regions (now districts), and the provincial government with decisions regarding the type and amount of services required to address increasing demand for beds. These guidelines were contingent upon the acceptance of the subcommittee's recommendations and were therefore, based upon the following assumptions: a comprehensive range of community-based service options will be developed and/or expanded to provide suitable alternatives to institutionalization; services will be targeted to those at most risk for

institutionalization; the implementation of single entry access; access to services will be based on assessed need; and facilities (providers) will receive funding consistent with identified resource needs of residents.

The Subcommittee noted that the planning of continuing care services requires an awareness and understanding of the many factors which affect the development and utilization of services. When demand for institutional-based services is identified, a number of factors must be reviewed to determine the type and amount of services required. As stated by the Subcommittee, an increase in beds may or may not be the most appropriate response to addressing demand for services.

The Advisory Committee on Capital Investment in Long Term Care has reviewed the guidelines recommended by the 1996 subcommittee and believe that they remain relevant today.

*1. **Document and Evaluate the Need for Increased Beds***
What indicators are used? Waiting lists; inability to place medically discharged patients from hospitals; increased stress for families and informal care givers; utilization of community-based services; availability of psycho geriatric care, palliative care, respite services, mental health services, geriatric assessment units; etc.? Are these indicator validated?

*2. **Review Waiting Lists for Institutional-Based Services***
Are individuals on the waiting list assessed and classified for placement in facilities? Were alternative services considered? Are names placed on more than one list? Have individuals deceased who are on the list? How many names are on the list? Are waiting lists centralized? What is the average waiting time on the list before placement? How does this compare with other areas? Have waiting times been increasing or decreasing? How many on the waiting list are presently occupying acute care beds?

*3. **Review Admission/Discharge Policies***
Are admissions to beds based on priority of need? If not, this is a major cause for concern and must be addressed. If individuals with priority needs are not admitted, it forces reliance on higher cost services such as hospital beds, or causes undue hardship and stress for individuals, their families and care givers. Are discharge policies in place?

*4. **Review Length of Stays***
What is the average length of stays for residents in a facility? Are the length of stays increasing or decreasing?

*5. **Review Turnover Rates***
What is the turnover rate of beds? Is this increasing or decreasing? Turnover rates should be increasing if suitable alternatives are available in the community and if residents are being admitted with higher levels of acuity, frailty and mental health

problems. A higher turnover rate of beds and decreasing length of stays will maximize the supply of beds available for new admissions.

*6. **Evaluate Alternative Services***

Is the amount and type of alternative community-based services available adequate to meet demand? What are the waiting lists for such services? The demand for beds in any given area will increase if alternative services are not provided. Alternative services may include, but are not limited to, in and out of home respite care and support services for families and informal care givers; geriatric assessment and rehabilitation services; housing options; age-in-place services, such as yard work and snow shovelling, which permit individuals to remain in their current homes, and may make a move to an apartment or facility unnecessary; help with personal and day to day living; support to persons and families of individuals with Alzheimer disease and other forms of dementia; adult day and night centres; outreach programs provided by various organizations in the community; and a broad range of comprehensive home care services. How are these alternatives financed? Do financial barriers prohibit elderly persons with lower socioeconomic resources from accessing services?

*7. **Targeting of Services***

Are alternative community-based services targeted toward elderly at risk for institutionalization? Early identification of individuals at risk could result in early intervention with specialized programs, which may reduce the need for admission to facilities. Dementia, the presence of a caregiver, recent hospitalization, poor self rated health and impaired function are significantly associated with increased risks of institutionalization. Other variables also increase the risk of institutionalization such as age, marital status, physical level and type of activity, use of an ambulatory aid, unavailability of informal support, home ownership, low household income and education levels, and over supply of nursing home beds. It is not the individual contributing factors that are significant but rather the increase in risk that a combination of these factors presents. It is the cumulative impact of these factors that are most important.

*8. **Review Utilization of Alternatives***

Are all alternative services to institutionalization considered before institutional placement? Do admission/discharge policies ensure that all possible alternative services have been exhausted before admission to facility beds? Utilization of institutional-based services should only be considered after other service options have been exhausted.

*9. **Establish Proximity of Other Nursing Homes***

What is the distance to the nearest nursing home? What problems does this present to individuals and families, etc.?

*10. **Define Bed Ratios***

Identify the current and future projected bed per 1000 population 75+ ratio for the catchment area. How does this compare to other regions? If it is higher than other areas, then try to determine why.

*11. **Review Fill-Up Rates***
What are the fill-up rates for any newly constructed homes or beds in the area? Fill-up rates will vary by region and facility size. A longer time to fill can indicate a saturation of demand.

*12. **Evaluate Funding Appropriateness***
Are homes appropriately funded to care for residents being admitted with higher levels of acuity, frailty and mental health problems? Without appropriate funding and resources, incentives may be built into the system to admit residents with lower acuity levels who could have been cared for by other services. This would increase the length of stays, decrease turnover rates and inappropriately inflate the need for beds.

*13. **Conduct Current Bed Review***
Review current beds to determine the numbers of beds that are occupied by residents who could be cared for by alternative services. This will provide an indication of systemic problems such as inappropriate admission/discharge policies, incentives to admit residents with lower acuity levels, and/or lack of alternative services available in the community. Caution is noted here, however. This would not mean that existing inappropriately placed residents should be discharged unless specifically requested by the resident. The facility is their home. The review would simply indicate problem areas that need to be addressed to prevent future inappropriate admissions.

*14. **Evaluate Community Need Assessments***
Have community need assessments been conducted? What are they revealing? Need assessments can help identify local needs from which suitable services can be developed.

*15. **Conduct Comparative Analysis***
Review what other communities and regions are doing to address these issues. What alternative services have been developed? What are their admission/discharge policies, bed per 1000 population ratios, support services for families and informal care givers, etc.? Are services targeted toward individuals at significant risk for institutionalization?

3.0 Capital Plan & Capital Funding

It is recommended that a long term care capital plan be created to identify and plan for the ongoing capital requirements of all long term care facilities in the province.

It is further recommended that the capital planning approaches recently deployed in Alberta and Ontario be studied for application in Nova Scotia.

For example, the average age of a nursing home in this province is 25 years. Most were designed and built in an era where residents were ambulatory and required lighter care needs than is being

experienced today. Subsequently, the advisory committee believes that the functionality and utility of existing long term care facilities to meet the care requirements of current and future residents must be assessed. Both Alberta and Ontario have developed new mandatory design standards, a functionality and utility assessment process, and a priority-ranking system for repairs, renovations and facility replacement. The advisory committee believes these systems have application within this province.

3.1 Short-term (3-24 months):

(a) Assess the age, current physical condition and functionality of current facilities.
(b) Develop and implement a transparent prioritization process for capital investment.
(c) The health and safety of residents and staff and compliance with regulatory frameworks to take priority for capital investment.
(d) Where there is a demonstrated need for replacement beds due to unacceptable functionality and utility of the facility, the current license holder will be the provider assuming that they meet existing standards of performance.
(e) Existing facilities with diminished bed need will have the impact on infrastructure costs analyzed and addressed in the operating budget.

3.2 Long Term (2-5 years):

(a) Establish facility design and construction standards.
(b) Establish maintenance standards for all facilities.
(c) Assess facilities against these design standards.
(d) Employ a transparent prioritization process.
(e) Create a long term capital plan which addresses functionality and utility based on district needs and projected demographic profile of nursing home residents in 2020 and/or normal amortization period.

Funding:

- The per diem rate will include a predetermined amount over a fixed period to cover the costs of new construction.
- The per diem rate of both new and existing beds will include a provision for ongoing capital maintenance.
- The committee recognizes that variables exist requiring further study of this recommendation.

3.3 Implementation Guidelines

The advisory committee recommends that an inventory of existing long term care facilities and a preliminary assessment of current physical condition and functuality be conducted.

3.3.1 Inventory of Deficiencies:

(a) List of urgent known deficiencies:

Copies of the reviews conducted by external regulatory agencies such as the Fire Marshall and the Department of Labor are routinely forwarded to the Department of Health. The annual inspection of facilities for licensure purposes will also provide valuable information on those facilities with urgent capital requirements. An immediate snapshot of urgent deficiencies can be compiled from this documentation. This snapshot could be prepared immediately pending other departmental priorities. **The advisory committee recommends that this listing be compiled as soon as possible.**

(b) Objective inventory of current condition:

Recognizing that the average age of a nursing home in this province is 25 years, the advisory committee believes that a more complete review of all nursing homes and residential care facilities is required. In the longer term, the functionality and condition of facilities should be assessed against design and maintenance standards, however, since existing standards in these areas require substantial revision, **the advisory committee is recommending that an inventory of the current condition of all facilities be conducted in the short-term.** This initial inventory and assessment will be a self-reported survey completed by each long term care provider. Timeline: September 30/00

- The DOH will develop a standardized reporting template for this exercise.
- A data base will be created from the survey results which can be broadened as more specific assessment criteria are developed in the longer term.
- Survey result will be analyzed with significant situations reviewed for action.

3.4 The advisory committee recommends that an **Infrastructure Standards Committee** be established immediately by the Department of Health to:

- develop design standards for LTC facilities.
- develop preventative maintenance standards for LTC facilities.
- develop a tendering process for the renovation or construction of LTC facilities.
- the composition of this committee should be comprised of stakeholders (LTC providers), DOH, Department of Housing and Municipal Services plus two independent, external consultants who are recognized within the LTC community. The recommended timeline for completion of this work is December 31/00.

3.4.1 Following the completion of these design standards, it is recommended that an external agency be employed to assess all existing facilities against these standards. An external agency is critical to accelerate this review and to enhance objectivity.

This assessment is to commence on April 01/01 and be completed by December 31/01.

Using the classification systems that exist in other provinces as a guide, the advisory committee has developed the following capital rating criteria.

Category A	Exceeds minimum standards
Category B	Meets minimum standards
Category C	Does not meet standard & needs major upgrade
Category D	Health and safety of residents/staff are at risk as determined by external regulatory body; and the facility has to be either renovated or replaced

Facilities would be placed in one of these categories based on the report of the external reviewer.

3.5 A long range capital plan be developed to address the capital needs identified through this external review.

3.6 Funding

- For those facilities with capital needs which impact on the health and safety of residents and/or staff, it is recommended that a transitional process be implemented which covers the required capital costs. Such capital costs are to be reflected in the facilities' per diem rate.

- It is recommended that a new funding approach to the per diem model be developed and implemented. This approach must hold providers accountable but also allow flexibility and incentives for innovative and cost-efficient operations.

  In Ontario, for example, three separate funding envelopes are allocated:
  Envelope A, which is non-portable, covers programming and nursing costs
  Envelope B, which is non-portable, covers food costs
  Envelope C, which is portable, covers accommodation and other costs, including capital.

- It is recommended that a standard amount be designated for ongoing facility maintenance and be provided to all facilities. Those facilities which are financing major construction projects would have an additional amount designated to cover the amortized cost of this construction. In Ontario major renovation and/or capital costs are funded at 100% on day one of occupancy. This policy addresses the reality that

regardless of occupancy, much of the capital expenditure is realized on day one. The advisory committee recommends that consideration be given to implementing a similar policy within this province. Further study is required to determine the most appropriate occupancy ratio upon which to base operational funding.

- It is further recommended that the cost of moving to an insured service such as exists in several other provinces be actively explored. The advisory committee believes that when the costs of administering our current and cumbersome funding system is factored in, that the more simplistic insured service approach would be advantageous in the longer run. An insured service would, in our opinion, create fairer and more equitable treatment of residents and families, give dignity to all residents, and contribute greatly to moving long term care into its rightful position as an equal partner in the continuum of health care services in this province.

3.7 Interim Strategy

Recognizing that the above capital assessment cannot be accomplished overnight and that major repairs and renovations are required for a number of nursing homes at this time, the committee is recommending an interim approach to respond to pressing situations. The committee strongly urges that this interim strategy be deployed only for those situations where regulatory bodies have determined that changes are required for the heaith/safety of residents/staff.

3.71 Is there compelling evidence that these long term care beds will not be needed in the long term?

Beds Will Be Needed:

a) Determine whether it is more cost effective to repair or to replace.
b) Approve construction plan based on present application of standards as a minimum and on the consideration of current & future resident's needs.
c) Funding for capital to be reflected in the facility's per diem rate.

Beds Will Not Be Needed:

a) Identify service/care gaps.
b) Develop and implement transition plan for the facility.

3.7.2 Will an existing facility be downsized (decreased number of beds) as a result of either facility repair or replacement? (The advisory committee recognizes that a critical mass is necessary to absorb infrastructure costs and create viable operations. It is possible that as facilities are downsized, the structures required to support quality resident care will not be viable and some organizations will collapse. This could be detrimental to the public interest.)

(a) The advisory committee recommends that the provider be given the option to replace these beds elsewhere in the province where:

- there is a demonstrated need for new or replacement long term care beds;
- current provider(s) in the community does not wish or is not in the position to replace or build these beds;
- the provider demonstrates the ability to meet clients' needs efficiently and effectively;
- the provider meets or exceeds existing standards of care and of asset protection in its operations elsewhere in the province.

(b) The advisory committee further recommends that the above provision be in place while the impact of single entry on the demand for nursing home beds is being assessed (a 24 month window is suggested).

4.0 Proposal Assessment

It is recommended that formal processes be developed for the procurement of services, the assessment of program proposals, and for monitoring compliance with these standards.

4.1 Short-term (3 - 24 months):

Enhance existing design/construction and procurement/tendering standards as interim assessment criteria.

- Apply these interim criteria consistently.

4.2 Long-term (2 - 5 years):

(a) Establish mandatory design/construction/maintenance standards (see recommendation #3); and establish mandatory procurement/tendering standards.

(b) Develop and implement a public call for proposals for all new programs and/or services.

(c) Apply all standards and processes consistently and fairly.

4.3 Implementation:

The advisory committee recommends that an Infrastructure Standards Committee be established immediately by the Department of Health, (see implementation under recommendation #3).

Next Steps

The Committee acknowledges the support which it has received from the Minister of Health, the Deputy Minister of Health, and senior officials of the Department in completing its mandate. Without the willingness of these individuals to share information with us and to make themselves available as needed, we would not have been able to complete our mandate within the available time frame. The Committee also thanks the Nova Scotia Association of Health Organizations (NSAHO) for the logistical support it has provided throughout our deliberations.

We encourage government to act quickly on our recommendations - in collaboration with all health care providers and other government departments - to address the capital investment issues within the long term care sector.

Success will follow if....

- those in the health system are able to manage care effectively and make the best use of available resources, programs, services and facilities.
- sector silos at the community and district levels no longer exist and an integrated health system in which all sectors collaborate and co-operate develops.
- sufficient resources - people and money - are in place.
- steps are taken to action the recommendations included in this report.

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12. Report of the Indoor Air Quality Regulation Working Group (Draft). Nova Scotia Department of Labor, 1998.

13. Personal interviews with officials of provincial/territorial governments; and personal interviews with health care providers in Alberta, Ontario and New Brunswick.